



TriWest Healthcare Alliance

Department of Veterans Affairs (VA) Patient-Centered Community Care (PC3 or PCCC) and Veterans Choice Program (VCP) Provider Handbook

Your Guide to PC3 and VCP Policies and Procedures

Using This Provider Handbook

This Provider Handbook provides you and your staff with basic, important information about the PC3 and VCP while emphasizing key operational aspects of the programs and their requirements. You may use this handbook to assist in coordinating care for Veterans.

This Provider Handbook is also available electronically on the TriWest Provider Portal at www.triwest.com/provider. The Provider Portal is your one-stop shop for information on filing claims and navigating these programs.

Thank you for your service to our nation's Veterans.

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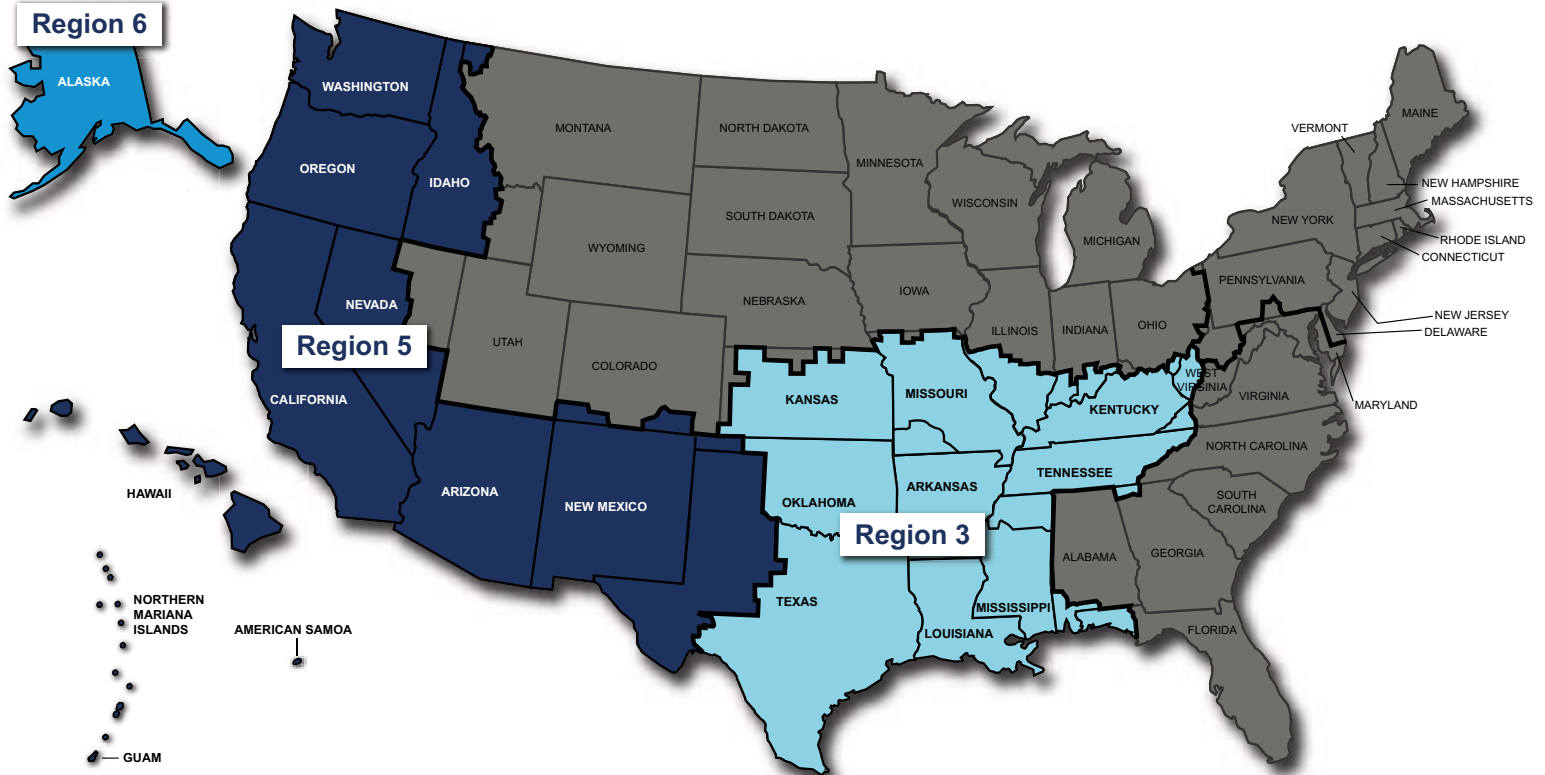
Regions

In the United States, the PC3 and VCP are divided into six separate regions.

- **Region One** – Connecticut, Maine, Massachusetts, Missouri, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, and West Virginia.
- **Region Two** – Alabama, Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, and Virginia.
- **Region Three** – Alabama (southern portion) Arkansas, Florida (western portion), Illinois (southern portion), Indiana (southern portion), Kansas, Kentucky, Louisiana, Missouri, Mississippi, Oklahoma, Tennessee, Texas, Virginia (western portion), and West Virginia.
- **Region Four** – Colorado, Indiana, Illinois, Iowa, Michigan, Minnesota, Montana, Nebraska, North Dakota, Ohio, South Dakota, Utah, Wisconsin and Wyoming.
- **Region Five** – Arizona, California, Colorado (southern portion), Hawaii, Idaho, Nevada, New Mexico, Oregon, Texas (western portion), Washington and the territories of American Samoa, Guam, and the Northern Mariana Islands.
- **Region Six** – Alaska.

Your Contractor

TriWest Healthcare Alliance (TriWest) is responsible for administering the PC3 and VCP in Regions 3, 5 and 6. TriWest is committed to offering eligible Veterans access to the finest health care services available.



Resources: Provider Portal

The TriWest Provider Portal is available as your one-stop shop for information on filing claims and navigating the PC3 and VCP. Access the resource anytime at www.triwest.com/provider.

The Provider Portal offers:

- **Quick reference guides** on topics like other health insurance and medical documentation requirements;
- **Live, interactive webinars** to help providers learn the health care management process for the PC3 and VCP, including the appointing and authorization process and billing procedures;
- **Frequently asked questions** on everything from medical documentation to determining a Veteran's eligibility

Registering for a Secure Account

TriWest strongly recommends providers register for a secure account on the Provider Portal, where they can access authorization information, upload medical documentation and view claims status. For technical assistance with the Provider Portal, email VAPortalAssistance@triwest.com or call the Provider Portal Assistance Line at 1-855-722-2838, x3, x2.

TriWest's Interactive Voice Response (IVR) System

TriWest offers an IVR system (**1-855-722-2838, option 3**) to assist providers with routine questions. Follow the greeting and select the applicable touch-tone prompts outlined below to get quick information and accurate answers on many topics:

- Press "1" with authorization questions
- Press "2" for assistance with the secure Provider Portal
- Press "3" for claims questions
- Press "4" for provider contracting

Program Governance

PC3 and VCP providers are obligated to abide by the rules, procedures, policies and program requirements specified in this Provider Handbook, which is a summary of the regulations and manual requirements related to the PC3 and VCP programs. Providers must read and understand the contents of this handbook outlining the governing statutes and regulations that provide final guidance for the PC3 and VCP programs. This handbook is **NOT** a substitute for legal advice from qualified counsel, as appropriate. VA regulations are available on the VA website at www.va.gov or www.ecfr.gov.

PC3 Network Providers

TriWest network providers under PC3 are those physicians, specialists, primary care, group practices, hospitals, facilities and ancillary providers who have signed contracts to become part of the TriWest network. Through the contract, providers agree to provide health care services to Veterans authorized by VA and TriWest.

PC3 Local Network Representatives

For providers who have signed network contracts with TriWest under the PC3 program, TriWest has subcontracted local network representatives to help them navigate the program.

PC3 network providers should contact their local network representative for assistance with:

- Provider demographic updates (e.g., change in tax identification number, physical location, contact information, and email addresses for staff working with PC3)
- Questions about their PC3 contract

VCP Providers

TriWest VCP providers are those physicians, specialists, primary care, group practices, hospitals, facilities and ancillary providers who have *agreed* to provide care to Veterans for each authorization sent by TriWest, and adhere to the VCP terms and conditions for each authorization. VCP providers are **NOT** under contract with TriWest, but still must adhere to the terms and conditions outlined in their authorizations if they choose to treat Veterans.

A separate telephone line has been established to assist providers with the VCP. For VCP assistance, please call **1-866-606-8198**.



Provider Credentialing Process

All services, facilities, and providers shall comply with all applicable federal and state regulatory requirements in their state or jurisdiction. Any provider on the Centers for Medicare and Medicaid Services (CMS) exclusionary list shall be prohibited from network or VCP participation.

TriWest will ensure that every procedure, test or other aspect of clinical care is performed by providers with demonstrated current competence, either through current, unrestricted privileges to provide the care as required by Medicare Conditions of Participation (CoP) and Conditions of Coverage (CfC), or other measures of demonstrated competency. Go to www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/index.html to review the current Medicare CoPs and CfCs.

Providers who have signed a contract to become a participant of the PC3 network will be credentialed by either TriWest or the local network representative. The credentialing process involves obtaining primary-source verification of the provider's education, board certification, license, professional background, malpractice history and other pertinent data. Credentialing and contracting packets may be obtained from the local network representative who assists in completing the paperwork and executing the contract. If you participate in the Council for Affordable Quality Healthcare (CAQH) simply provide your CAQH ID on the form in lieu of the full credentialing application. A credentialed provider who has signed a contract is considered a network provider once they are informed of the final notification of contract execution by the local network representative.

For additional credentialing requirements based on the VA-specialty specific requirements, please reference the [Provider Credentialing Quick Reference Guide](#).

Note: It is imperative that PC3 providers wait for final notification of contract execution from their local network representative before providing care to Veterans as network providers.

Provider Responsibilities

The agreements for providers participating in the PC3 or VCP outline the provider responsibilities under these programs. The following are certain provider responsibilities and requirements for both PC3 and VCP:

- If Provider enters into any subcontracts with any subcontractors whereby such subcontractor assumes any of Provider's duties, responsibilities, or other obligations under this Agreement, Provider assumes full responsibility for credentialing, licensure, and professional liability insurance of said subcontractor and shall ensure that any such subcontracts require subcontractors to comply with the terms and conditions of this Agreement.
- Provider agrees to comply with all policies and procedures set forth in this Provider Handbook, including, without limitation, credentialing, peer review, utilization review/management, medical documentation sharing, quality-assurance programs and procedures established by TriWest or VA, including concurrent reviews, retrospective reviews, and discharge planning for inpatient admissions.
- Provider agrees to accept the PC3-contracted reimbursement rates or the VCP reimbursement rates as the only payment expected from TriWest for Veterans covered under either program for authorized services.
- Veterans have no co-pays or cost-shares in this program. As such, a Veteran will not be billed directly for any services or supplies furnished under this contract.
- VA regulations prohibit PC3 or VCP providers from charging missed appointment fees.
- Provider understands and agrees that all covered services provided to Veterans, except emergency services, must be authorized by VA and TriWest.
- Provider agrees to meet office and appointment access standards (Veteran should be seen within 20 minutes of a scheduled appointment and a Veteran appointment should be scheduled within 20 days of TriWest requesting an appointment with the provider), as noted below in the Office and Appointment and Access Standards section.
- Provider will include his or her National Provider Identifier (NPI) and the authorization number for the episode of care when submitting claims for health care services.

- Provider agrees to submit all claims for covered services on behalf of Veterans. All claims should be submitted electronically. Providers who do not have the ability to submit claims electronically can find additional information in the [Provider Claims Quick Reference Guide](#).
- Secondary authorization and continued care requests should be submitted by fax to: 1-866-259-0311.
- Provider agrees to submit medical documentation for an authorized episode of care to TriWest within the timelines outlined in the [Medical Documentation Quick Reference Guide](#). Providers agree that when providing covered services to Veterans under PC3 or VCP, they will not discriminate against any Veteran on the basis of his or her race, color, national origin, or any other basis recognized in applicable laws or regulations.
- Provider will provide Veterans with a copy of their medical records at no charge, including a narrative summary and other documentation of care, within 10 business days of the request.
- The Provider shall notify TriWest within 24 hours of discovery of all Veteran safety events that are sentinel events, adverse events (including adverse drug events), or intentionally unsafe acts. Adverse events involving administration of drugs shall be reported to TriWest using the Food and Drug Administration (FDA) Form 3500. A copy of the completed form shall be submitted to the FDA online and shall also be submitted to VA. The FDA reporting form can be found at: www.fda.gov/Safety/MedWatch/HowToReport/default.htm.
- Provider agrees to submit at least one email address to TriWest for purposes of communicating important PC3 or VCP updates.
- Facilities that perform cardiac catheterizations and/or percutaneous coronary interventions and implanting cardioverter defibrillators (ICDs) are required to participate in the National Cardiovascular Data Registry (NCDR) CathPCI and NCDR ICD, respectively.
- Provider agrees to comply with all final HIPAA ASC X12N Transactions and Code Sets standards as promulgated by the secretary of HHS.
- Provider or designee should receive initial and periodic web-based training to obtain and enhance understanding of PC3 or VCP requirements.
- Provider agrees to notify his or her local network representative (for PC3 network providers) or TriWest (for VCP providers) of any changes of tax identification number (TIN), physical and/or mailing address, phone or fax number, whether the Provider is accepting new patients or specialty services rendered and email address for staff working with PC3 or VCP, within 10 business days of the change.

Updating Provider Demographic Information

It is important for providers to report any outdated or incorrect demographic information—such as changes in physical/ mailing address, phone, fax, tax identification number, or email address—as soon as possible to their local network representative or TriWest directly. This enables TriWest to provide accurate information to Veterans, ensures claims are paid appropriately and guarantees payments are mailed to the correct address. To update your information:

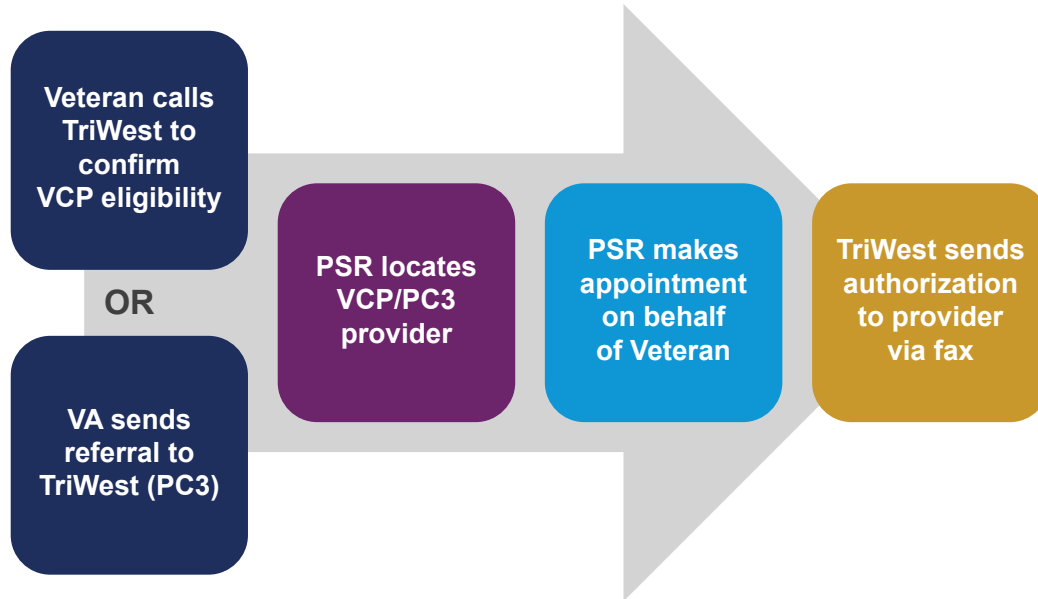
- **For PC3 network providers:** contact your local network representative.
- **For VCP providers:** call TriWest at 1-866-284-3743



Appointing and Authorization Process

The appointing and authorization process may vary depending on whether the Veteran is participating in the VCP, or VA refers the Veteran directly to TriWest through PC3. Either way, TriWest makes the appointment for the Veteran and then faxes an authorization to the provider. **The provider must have an authorization on file BEFORE rendering care to ensure payment for services.**

TriWest's goal is to improve clinical coordination by utilizing TriWest's Patient Service Representatives (PSRs) to ensure timely appointments for Veterans.



*Please note that the appointing process is different in Alaska. Visit www.triwest.com/provider-alaska for more information.

If the Veteran is using the VCP (i.e. the Veteran presents his or her Choice Card at the front office), it is the VETERAN'S responsibility to call the number on the back of the Choice Card and confirm eligibility—not the provider's. Once eligibility is verified, TriWest will schedule an appointment for the Veteran with the provider and send the provider a detailed authorization letter.

If VA sends a referral request (PC3) directly to TriWest, TriWest will call the provider to schedule an appointment for the Veteran and send the provider a detailed authorization letter. VA will send a Veteran to another provider when the requested service is outside the scope of practice for the VA medical center, or VA is unable to provide the services in a timely manner.

To reiterate, authorizations are required for all services and procedures under PC3 and VCP. If providers render care without an authorization, they risk losing reimbursement and may NOT bill the Veteran. Additionally, VA requires medical documentation for all services to ensure coordination of care for Veterans.

Please refer to the [Appointment Scheduling Process Quick Reference Guide](#) for more information.

Note: No payment will be made for services not authorized by VA and TriWest.

Access to Care Standards

The Veterans Health Administration (VHA) has established access to care standards for the PC3 and VCP programs. These standards address appointment availability, wait time once the Veteran arrives at the office and drive time standards. The drive time is based on the distance from the Veteran's residence address to the provider service location. These standards are monitored and reported to VA on a regular basis. PC3 local network representatives will work to contract providers to comply with these standards and assist providers with compliance.

Drive time standards are based on the geographic area and defined as:

- **Urban** – Census Bureau-defined urbanized area, which is any block or block group having a population density of at least 1,000 people per square mile
- **Rural** – Any non-urban or non-highly rural area
- **Highly Rural** – an area having less than 7 civilians per square mile

Appointment Scheduled:

- Within 20 calendar days of TriWest receiving the referral from VA, or the Veteran calling the number on the back of his or her Choice Card

Office wait time:

- 20 minutes from scheduled appointment

Basic drive time standards:

- **Urban** – within 45 minutes' commute time
- **Rural** – within 100 minutes' commute time
- **Highly Rural** – within 180 minutes' commute time

For Veterans whose condition requires a higher level of care, the following drive-time standards apply:

- **Urban** – within 90 minutes' commute time
- **Rural** – within 180 minutes' commute time
- **Highly Rural** – within the community standard commute time

For Primary Care Network Access, the time distance standards are as follows:

- **Urban** – within 30 minutes' commute time
- **Rural** – within 45 minutes' commute time
- **Highly Rural** – within 60 minutes' commute time

For Women's Health, the standards are as follows:

- **Mammograms** and **Maternity Care** must be accessible within 50 mile distance or 60-minute maximum commute time (whichever is the lesser commute)

Authorization Letters

To initiate the appointing and authorization process, VA may send a referral directly to TriWest for a Veteran (PC3), or a Veteran may call the number on the back of their Choice Card and request to be seen under the VCP.

In both instances, a TriWest PSR will schedule an appointment for the Veteran and then generate a detailed authorization letter to the provider via fax.

The authorization letter will identify whether the episode-of-care is for PC3 or VCP (also called Choice). **All services require prior authorization in order for the provider to receive payment.**

Secondary Authorization Requests

A provider who believes additional or continued care is required should visit the Secondary Authorization Request (SAR) Decision Tool on the TriWest Provider Portal at www.triwest.com/provider-SAR. Use the tool to determine whether a SAR is necessary. If so, complete the SAR form (the tool will link to it) and include notes, discharge plans and justification for the request for additional services. Fax all materials, including the completed SAR form, to TriWest at 1-866-259-0311.

Note: The SAR process differs for Alaska providers. For more information, visit www.triwest.com/provider-alaska.

Providers usually need to send a SAR when:

- A Veteran needs additional care from another provider or office with a different Tax ID Number (TIN);
- A Veteran needs a second opinion;
- A Veteran needs continued care outside of the authorized date range (available on the authorization letter); or
- A Veteran needs additional services not included on the original authorization letter.

Inpatient Care Coordination and Transfer Process

TriWest will coordinate and communicate admissions and discharges with an inpatient facility whenever inpatient health care is ordered and approved by the overseeing VA medical center. Care coordination will be performed by VA or TriWest in coordination with network facilities.

For discharges, the provider will coordinate with TriWest to arrange for necessary supplies, home health services and equipment. The provider needs to complete the [SAR form](#) and submit it to TriWest to obtain approval from VA. All transitions of care need to be approved by the VA medical center. TriWest will coordinate with the authorizing VA to facilitate the transfer of the Veteran back to a VA facility or another facility. TriWest will also coordinate discharge planning to the Veteran's home if other services are required. The VA medical center will approve the number of services, treatments and/or procedures.

Emergency Health Care Process

Emergency care should be provided to any Veteran who self-presents to an emergency room (ER) seeking emergency care.

All ER care is coordinated directly through VA, not TriWest. If a Veteran self-presents to an ER, the ER must call the Veteran's VA medical center **within 72 hours**.

VA will need to know:

- Veteran's full name
- Last four digits of the Veteran's Social Security number
- The condition for which the Veteran is being seen
- The mode of transportation by which the Veteran arrived. If by ambulance, a copy of the trip report should be provided, if possible

VA health care staff will determine the Veteran's eligibility and authorize care. If the Veteran is eligible, VA will issue an authorization to TriWest.

If the Veteran is being seen for authorized care and, during treatment, it is determined the Veteran is experiencing an emergency, the treating provider/facility must render emergency treatment immediately and notify VA. Additionally, the local ER that receives the Veteran must follow the steps above.

If a Veteran is receiving authorized services and the treating facility determines the Veteran needs a higher level of care than its facility is capable of providing, it must obtain authorization from VA prior to transferring the Veteran to another facility.

Providers should notify VA **within 72 hours** of an emergency admission. This also applies to weekend notifications.

In the event that care is not authorized by VA, the provider must submit claims within 90 days of the encounter directly to VA for reconsideration. No separate payment will be made for ER facility charges for inpatient services authorized under this contract that are subject to reimbursement under the [VA Inpatient Acute Care Prospective Payment System](#).

Urgent Care Process

Urgent care is defined as care considered essential to evaluate and stabilize conditions that may result in

loss of life, limb or vision; or care that, if not provided, will likely result in unacceptable morbidity/pain when there is significant delay in evaluation or treatment.

Authorizations containing the notation of "urgent" require TriWest to schedule the Veteran for care to a provider within 48 hours. If a Veteran needs urgent care and wants to use the VCP, he or she must call the number on the back of the Choice Card to make an appointment.

Regarding medical documentation, providers will be informed if VA specifies the need for an oral report in addition to the written report. All contacts to VA should be notated within the returned medical documentation.

Critical Findings Notification Process

VA defines Critical Findings as a test result value or interpretation that, if left untreated, could be life threatening or place the Veteran at serious health risk. Critical values/results are those results from laboratory, cardiology, radiology departments and other diagnostic areas that, upon analysis, are determined to be "critical," regardless of the ordering priority.

VA requires that for any Critical Finding test result, the provider shall notify the VA point of contact (POC) **by phone within 24 hours** of the test/evaluation/treatment.

It should also be noted in the medical documentation who the provider spoke to at the VA medical center and when the POC was notified.

- A new diagnosis of cancer is considered a Critical Finding and notification to the VA POC shall be made **within 48 hours of diagnosis**
- A newly identified suicide risk in a Veteran *not referred* for inpatient mental health should be considered a Critical Finding and the provider shall contact VA by phone **within 24 hours**

Immediate notification (within 24 hours) to a VA POC is required if the provider determines that the Veteran requires the following:

- Urgent follow-up after completion of authorized episode of care
- Urgent additional care during the authorized episode of care

Refer to the Critical Findings section of the [Medical Documentation Quick Reference Guide](#) for more information.

Medication Process

Pharmacy is included in all authorization letters; however, VA is primarily responsible for supplying Veterans with non-urgent/emergent medications, medical/surgical supplies and nutritional products. These must be prescribed in accordance with the [VA National Formulary Handbook](#), which includes provisions for requesting non-formulary drugs.

Always fax both the authorization and prescription to the appropriate VA medical center. If the Veteran prefers to take his or her script to the VA Pharmacy, he or she will also need to bring the authorization.

When there is an urgent/emergent need to start a medication and it is not possible to obtain the medication from a VA Pharmacy, the provider may write a prescription for up to a 14-day supply (without refills). The Veteran should be informed by the provider that an emergency prescription may be obtained from a non-contracted source, and VA will reimburse the Veteran directly.

If the urgent/emergent medication is filled at a non-VA pharmacy and is expected to be continued beyond 14 days, a second prescription should be submitted to a VA Pharmacy for processing. Follow the guidelines above.

If the medication is not on VA's drug formulary, the provider must contact its local VA Medical Center and request a Formulary Review Request Form. The provider should fill out the form and return it to the VA Medical Center for approval or denial. This process can take up to 96 hours for review.

Veterans who consent to participate in Human Subject Research studies and are enrolled in clinical trials cannot be authorized for those services under the PC3 or VCP programs. Veterans must be referred back to their respective Non-VA Care Office for the administration and coordination of non-VA care authorizations for care concomitant with clinical trials.

For more information on the pharmacy process, please visit the Pharmacy Page on the TriWest Provider Portal at www.triwest.com/provider-pharmacy.

Mental Health Care Services

This section will assist you with specific mental health care aspects of PC3 and VCP. You may also

refer to the [Mental Health Services Quick Reference Guide](#) for additional information and important website links.

For both inpatient and outpatient mental health care, providers should follow the Veterans Affairs/ Department of Defense (VA/DoD) Clinical Practice Guidelines (CPGs) for the diagnosed mental health problem found at www.healthquality.va.gov. These are baseline criteria and should not replace clinical judgment.

VA covers services delivered by qualified, authorized mental health care providers practicing within the scope of their licenses to diagnose and/or treat mental health components of a medical or psychological condition. **PLEASE NOTE:** all psychotherapy notes **shall be kept separate** from the Veteran's medical record, per Health Insurance Portability and Accountability Act (HIPAA) regulations.

However, medication prescription and monitoring (as appropriate), counseling session start and stop times, modalities and frequencies of treatment, results of clinical tests, and any summary of diagnosis, functional status, treatment plans, symptoms, prognosis or progress shall be provided in the medical record and do not require Veteran authorization for disclosure.

Veterans with a history of Military Sexual Trauma (MST) being treated for a mental health problem related to MST will receive care from a provider of the gender of their choice.

If suicide risk is a clinical issue, the Veteran shall be provided a written copy of the Veteran's personal Suicide Prevention Safety Plan (reference www.mentalhealth.va.gov/docs/VA_Safety_planning_manual.pdf). The plan will include the Veterans Crisis Line telephone number: 1-800-273-8255.

Any newly identified suicide risk in a Veteran not referred for inpatient mental health treatment shall be considered a Critical Finding, and therefore must be called into VA within 24 hours.

Labor, Delivery, and OB/GYN Prenatal Care

For labor, delivery and OB/GYN prenatal care, providers should follow the Veterans Affairs/

Department of Defense (VA/DoD) Clinical Practice Guidelines (CPGs) for pregnancy management at www.healthquality.va.gov. These are baseline criteria only and should not replace clinical judgement.

Patient Safety

TriWest PC3 and VCP providers are responsible to abide by patient safety programs that support VA requirements. TriWest is responsible for the oversight of clinical care provided to our Veterans and will review adverse events, sentinel events, close calls and intentionally unsafe acts. TriWest providers must agree to make their medical records available for review upon request for quality purposes.

www.jointcommission.org/Sentinel_Event_Policy_and_Procedures

Submitting Claims and Medical Documentation

TriWest, on behalf of VA, is the primary and only payer for all claims filed under both VA community care programs. VA also requires that providers submit medical documentation to TriWest for all services to ensure coordination of care for Veterans. Medical documentation should be sent to TriWest and claims should be sent to Wisconsin Physicians Service (WPS), TriWest's claims processor.

All services require prior authorization from TriWest to prevent claims denials. Additionally, claims should be submitted within 30 days after services have been rendered. No payment will be made for claims submitted after 120 days. Providers also collect no copays, cost-shares or deductibles from Veterans. To properly submit claims, follow these steps:

1. Upload medical documentation to TriWest Provider Portal

- Register for a secure account on www.triwest.com/provider
- Upload medical documents directly to the TriWest Secure Provider Portal
- If unable to access the portal, fax the medical documentation to TriWest at 1-866-259-0311

2. Submit claims to WPS

- Send claims electronically by calling WPS at 1-800-782-2680 (Option #1) and setting up an EDI; or
- Send claims via mail to the address:
WPS – VAPC3
PO Box 7926
Madison, WI 53707-7926

You may check the status of your claims anytime through the TriWest Secure Provider Portal at www.triwest.com/provider. For more information on filing claims, read the [Provider Claims Quick Reference Guide](#).

Medical Documentation Requirements

As stated before, medical documentation is required for **all services** provided to a Veteran to ensure coordination of care. VA requires medical documentation include the initial appointment and end-of-episode-of-care records only. Below are the timelines for submitting medical documents:

Outpatient care:

- VCP: 75 calendar days
- PC3: 14 calendar days

Inpatient care:

- VCP and PC3: 30 business days

Urgent care:

- VCP: 2 business days
- PC3: 48 hours

The authorization may request medical documentation be returned sooner than the timelines above, based on clinical need. A phone call may be required when results or clinical findings necessitate an urgent response.

VA requires providers submit all medical documentation to TriWest to ensure coordination of care for Veterans. Providers are strongly encouraged to submit their medical documentation through TriWest's Secure Provider Portal.

For more details on medical documentation requirements, such as the type of information to include, read the [Medical Documentation Quick Reference Guide](#).

Specialty Provider Guidelines and Additional Documentation

VA has additional documentation guidelines for two types of specialty providers. Those specialties are:

- [Radiation Oncology](#)
- [Gastroenterology](#)

Please click on the respective specialty to read the full details in its corresponding quick reference guide. Both guides can be found under the "Quick

Reference Guides” section of the Provider Portal at www.triwest.com/provider.

Reimbursement Methodologies

Reimbursement rates and methodologies are subject to change per VA guidelines. The provider agrees to accept as payment for the services provided the amounts agreed to under the terms set forth in his or her PC3 contract with TriWest or VCP agreement. Furthermore, the provider understands that no payment may be made for services that were not authorized by VA and TriWest.

VA prohibits providers from balance billing Veterans.

The provider acknowledges and agrees that PC3, VCP and Medicare program reimbursement methodologies and amounts may be adjusted periodically and, when effective, will supersede the reimbursement amounts and methodologies set forth in his or her PC3 contract with TriWest, or VCP agreement.

When a given medical procedure is not payable under Medicare rules, or is payable under Medicare rules but does not have established pricing at the national or local level, the provider will be reimbursed using verifiable usual and customary charges.

When a given medical procedure is not payable under Medicare rules, or is payable under Medicare rules but does not have established pricing at the national or local level, the network provider will be reimbursed using verifiable usual and customary charges.

Health Insurance Portability and Accountability Act (HIPAA) of 1996

VA generally adheres to the U.S. Department of Health and Human Services (HHS) rules implementing administrative simplification, including privacy and security. VA also complies with the 1974 Privacy Act. For more information on VA privacy procedures, please go to www.dtic.mil/whs/directives/corres/pub1.html and www.privacy.va.gov/index.asp.

Complaint Process

If a provider or a Veteran has concerns about the level or quality of services or care received through PC3 or VCP, he or she has a right to file a complaint with TriWest. TriWest will work with VA to resolve complaints. You may contact TriWest at 1-855-722-2838.

Additional Provider Resources

Below is a list of resources that may be helpful when providing services to Veterans.

TriWest Provider Portal: www.triwest.com/provider

VA/DoD Clinical Practice Guidelines: www.healthquality.va.gov

VA National Formulary: www.pbm.va.gov/PBM/nationalformulary.asp

Wisconsin Physician Services (WPS): www.wpsic.com/edi/index.shtml



Provider Contract Provisions

The following provisions are applicable to services rendered pursuant to authorizations for care under the Department of Veterans Affairs (“VA”) Community Care Network Program (“CCN”), as administered by TriWest Healthcare Alliance Corp. (“TriWest”), and will be incorporated by reference into the Provider’s Network Agreement as if fully set forth therein.

Definitions

All defined terms herein have the same meaning as they have in the Provider Network Agreement or Program Terms & Conditions unless otherwise defined below.

1. **Party** – Any individual or entity that is a party or a third-party beneficiary to the Provider Network Agreement.
2. **DME** – Durable Medical Equipment to include any equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness or injury, and is appropriate for use in the home.
3. **Beneficiary** – Any individual enrolled and authorized to receive care through the TriWest Provider network by any Program incorporated into the Provider Agreement.
4. **Provider** – Any individual or entity providing healthcare services pursuant to an authorization for care issued by TriWest, or who is otherwise subject to the terms and conditions of a Program or this Handbook.

Termination

TriWest and Network Subcontractor shall have the right to immediately terminate Provider Agreements upon written notice to Provider upon the occurrence of any of the events listed below:

1. Provider’s state or federal license or authorization to do business is reduced, restricted, suspended, or terminated (either voluntarily or involuntarily), or Provider’s other applicable license or accreditation necessary to perform any services contemplated by the Provider’s Agreement is reduced, restricted, suspended, or terminated (either voluntarily or involuntarily); or
2. Provider’s professional liability coverage as required under Provider’s Agreement is reduced below required amounts or is no longer in effect; or
3. Provider fails to meet TriWest’s or Network Subcontractor’s credentialing, re-credentialing, quality management or utilization management criteria, or fails to comply with quality management or utilization management processes; or
4. Provider fails to provide material information or provides erroneous information on Provider’s credentialing application or re-credentialing application; or
5. Provider is no longer Medicare-eligible, Medicaid-eligible, or is not eligible to participate in another government program; or
6. Provider or any one of its officers is arrested or indicted on felony charges that directly or indirectly relate to provisions of services under Provider’s Agreement, and TriWest and Network Subcontractor makes a reasonable and good faith determination that the nature of the charges are such that termination or necessary to avoid unnecessary risk or harm to Beneficiaries that could occur during the pendency of the criminal proceedings.

Notification

- A. All notices and other communications to a Party must be in writing, hand delivered, delivered by prepaid commercial courier services with tracking capabilities, faxed, or delivered by the U.S. mail to the address listed on the signature page of the Provider’s Agreement. The Parties may change the address of record by notifying the other Party of the new address. Notice shall be complete upon the earlier of actual receipt or five (5) days after being deposited into the U.S. mail. Notices and other communications in writing need not be mailed either by registered or certified mail, although a signed return receipt received through the U.S. Post Office shall be conclusive proof between the Parties of delivery of any notice or communication and of the date of such delivery.
- B. Provider shall notify TriWest or Network Subcontractor in writing immediately upon learning of any action, policies, determinations or internal or external developments that may have a direct impact on

Provider's ability to perform its obligations under the Provider's Agreement. Such matters shall include, but are not limited to:

1. Any change in ownership, specialty services provided, Medicare designation (including but not limited to sole community, critical access, etc.) or location of facility(ies);
2. Action against or lapse of Provider's license, certification, accreditation or certificate of authority;
3. Loss of hospital privileges;
4. Arrest or indictment;
5. Reduction in insurance coverage below the required limits set forth for the applicable Program, or termination of insurance coverage;
6. Any activity that compromises the confidentiality and security of the medical records of Beneficiaries;
7. Exclusion or any other penalty from Medicare, Medicaid, or any other federal health care program.

Provider Directory

TriWest may periodically include Provider's name, gender, work address, work fax number, work telephone number, whether the Provider is accepting new patients, specialty and sub-specialty and willingness to accept Beneficiaries in a directory of Network Providers. Provider is responsible for notifying TriWest or Network Subcontractor of any changes of address, phone or fax number, or specialty services rendered within ten (10) business days.

Compliance

Provider shall comply with all applicable state and federal laws as well as regulations and all rules, policies and procedures of the applicable program including without limitation to credentialing, peer review, referrals, utilization review/management, clinical practice guidelines, case management and quality assurance programs and procedures established by TriWest or the applicable health care program including submission of information concerning Provider and compliance with Preauthorization requirements, care approvals, pharmacy, dental and DME utilization requirements, care approvals, concurrent reviews, retrospective reviews, discharge planning for inpatient admissions, critical event notifications, quality of care audits, return of medical records and Prior Authorization of referrals.

VA-Specific Requirements for Certain Services and Professionals

- A. Office-based Diagnostic and Therapeutic Tests and Procedures – tests and procedures must be performed in a safe manner by qualified physicians within their scope of practice; which includes ensuring that physicians are appropriately trained and proficient in performing the procedures.
- B. Vision Rehab and Education Professionals – providers of blind or low vision rehabilitation must be certified by the Academy for Certification of Vision Rehabilitation & Education Professionals (ACVREP).
- C. Radiology Practice (all types) Radiology Technologists
 - i. Certified by the American Registry of Radiologic Technologists (AART)
 - ii. Mammography technologists must have advanced AART certification in Mammography.
- D. Sedation—ensures that processes using sedation during a procedure conform to the requirements in Medicare Conditions of Participation for medical centers or ambulatory surgical centers.
- E. Evidence-based Psychotherapies (EBP) - providers of EBP shall have received specialized training and experience in the EBP.
- F. Primary care includes, but is not limited to, medical diagnosis and medically necessary treatment provided, predicated on evidence-based principles of care (Reference: VA/DoD Clinical Practice Guidelines & US Preventative Services Taskforce <http://www.healthquality.va.gov/index.asp>). Primary care is directed toward health promotion and disease prevention, including the management of acute and chronic medical conditions. Primary care providers must coordinate, through TriWest, for any additional care needed using established points of contact (POC) and processes. Ancillary services such as labs, radiology, pathology that are not included in the primary care authorization and cannot be performed within the providers' office setting also must be coordinated with TriWest to ensure the use of TriWest network providers, or VA facilities. Diagnostic and treatment services that were not previously authorized such as MRI, CT, or any procedure that requires conscious sedation, must be preauthorized by TriWest.

- G. A primary care visit shall consist of an appropriate face-to-face office visit and should include history of present illness, system review, and a physical exam appropriate for the patient's complaint(s), clinical assessment, diagnosis, and treatment. Provider shall provide access to routine diagnostic tests include Complete Blood Count, Urinalysis, routine chemistry tests, Partial Thromboplastin Time, Prothrombin Time/International Normalized Ratio, standard 12-lead electrocardiogram, and Fecal Occult Blood Test. Routine diagnostic radiology includes chest x-ray (Antero Posterior/Lateral) and extremity, abdomen, spine, bones and joints. These and other diagnostic tests shall be conducted when determined medically appropriate for patient care, such as when requested to support VA's clinical quality performance measure guidelines. The Provider shall provide preventive services to include gender appropriate adult health screenings and counseling as recommended by the U.S Preventative Services Task Force and other VA quality performance standards (VA/DoD Clinical Practice Guidelines—<http://www.healthquality.va.gov/index.asp>). This includes smoking cessation counseling, routine vaccinations (e.g. pneumococcal and influenza vaccinations), screening mammography, cervical cancer screening, colon cancer screening, screening for mood disorders, substance abuse, etc. as clinically appropriate. Screening mammography shall only be provided to participants by the Provider if authorized by VA. Additionally, offering continual education to patients about diseases, medications, and healthy lifestyles is required. The Provider shall ensure Veterans appointments are conducted by an appropriately certified Medical Doctor (MD), Nurse Practitioner (NP), Doctor of Osteopathy (DO), or Physician Assistant (PA) licensed and working within the scope of their practice and licensed within the state where the services are rendered. TriWest will ensure that Providers have effective on-call coverage.
- H. Provider is responsible for performing the required services and documenting that performance in a progress note. The Provider shall provide progress notes after services are provided. The progress notes shall include scheduled encounter date and time, time patient was seen, current problem list, medication reconciliation, and recommended follow on treatments, if any. The progress note content should be commensurate with elements of medical practice documentation standards and accurately/ completely reflect the care rendered. Timing and frequency of all patient care shall be based on patient needs. Progress notes must be included with all medical documentation and in accordance with current medical documentation return requirements

Insurance Requirements

Provider shall provide and maintain policies of general and professional liability (malpractice) coverage to insure Provider and each employee or agent of Provider against any claim for damages arising by reason of personal injury or death resulting directly or indirectly from the performance of this Agreement. Such coverage shall be subject to the approval of TriWest or Network Subcontractor and be in an amount equal not less than either (1) the amount required by the law of the state where Provider practices, (2) the amount required by the Provider's participation in a state liability pool/fund, or (3) in the absence of applicable state law or state pool/fund, the community standard for such coverage, but no less than One Hundred Thousand Dollars (\$100,000) per occurrence and Three Hundred Thousand Dollars (\$300,000) aggregate. Provider shall provide Network Subcontractor with a certificate of such coverage upon execution of this Agreement and shall provide Network Subcontractor thirty (30) days' prior notice of any change in coverage or termination of expiration of coverage. If coverage is on a claims-made basis, Provider shall ensure employed physicians have proof of tail insurance satisfactory to TriWest or Network Subcontractor upon any termination of coverage and containing an extended reporting endorsement for a period of not less than three (3) years after the termination of this Agreement.

Medical Documentation Guidelines

Medical documentation recording the delivery of authorized VA PCCC Covered Services shall be submitted to TriWest in the form and within the timeframes required by the VA PCCC program, but in no event later than fourteen (14) calendar days after completion of the outpatient services and thirty (30) calendar days after discharge for inpatient care. Provider shall provide TriWest with a valid email address and receive communication from TriWest via email. To the extent practicable, Provider shall use electronic methods (e.g. email, secure website, etc.) in performing transactions for the VA PCCC program.

Claims Submission Rules and Procedures

The following guidelines are necessary in order to submit claims electronically to TriWest via Wisconsin Physicians Services (WPS):

1. In transmitting EDI, Provider will transmit such claims edited and formatted according to the specifications indicated within the most current Provider User Guide or the ANSI X12 837 Implementation Guide and EDI Companion Guide supplied by WPS. Provider understands the WPS Provider User and EDI Companion Guide are proprietary and are authorized for use only by Provider and its employees working on behalf to transmit such EDI and that any other use or distribution of the WPS Provider User Guide or EDI Companion Guide is strictly prohibited without the express written consent of WPS. WPS shall be the final authority in resolving any disputes about how electronic data shall be submitted.
2. Provider agrees that all claims submitted via EDI, for all legal and other purpose, will be considered signed by the Provider or Provider's authorized representative.
3. Provider agrees to maintain a patient signature file. Provider understands WPS may validate through file audits, those claims submitted via EDI which are included in any quality control or sampling method required by WPS. Provider understands if no signed authorization is on file, an authorization must be obtained by the Provider from the patient prior to EDI submission to WPS.
4. Provider acknowledges that WPS and Network Subcontractor shall have no obligation with respect to the content of the information in claims either to verify, check or otherwise inspect the information supplied by the health care provider, except to reformat the claim data to the specification required by TriWest. Provider further acknowledges that TriWest will determine whether Provider has submitted enough information in the EDI claims in order to determine the completeness, accuracy and validity of the information and claims and that source documents for claims data the responsibility of the Provider.



Acronyms

CoP – Medicare Conditions of Participation

CPGs – Clinical Practice Guidelines

CPT – Current Procedural Terminology

CQM – Clinical Quality Management

DME – Durable Medical Equipment

DMEPOS – Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

DoD – Department of Defense

DRG – Diagnosis-Related Group

EDI – Electronic Data Interchange

EFT – Electronic Funds Transfer

EOB – Explanation of Benefits

ER – Emergency Room

ERA – Electronic Remittance Advice

FL – Form Locator

HCPCS – Healthcare Common Procedure Coding System

HHA – Home Health Agency

HHS – U.S. Department of Health and Human Services

ICD – Implanting Cardioverter Defibrillators

ID – Identification

IDME – Indirect Medical Education

IVR – Interactive Voice Response

MD – Medical Doctor

MRI – Magnetic Resonance Imaging

NDC – National Drug Code

NCDR – National Cardiovascular Data Registry

NP – Nurse Practitioner

NPI – National Provider Identifier

OPPS – Outpatient Prospective Payment System

PA – Physician Assistant

PCS – Primary Care Services

PC3 or PCCC – Patient-Centered Community Care Program

PDTS – Pharmacy Data Transaction Service

PPS – Prospective Payment System

SSN – Social Security Number

TIN – Tax Identification Number

UAC – Usual and Customary

VA – Department of Veterans Affairs

VACAA – Veterans Access, Choice and Accountability Act of 2014

VAMC – Veterans Affairs Medical Center

VCP – Veterans Choice Program

VHA – Veterans Health Administration

VNAF – VA National Formulary

WPS – Wisconsin Physicians Service

If you have any questions regarding this information, please contact TriWest using the Provider Customer Service contact listed below for the appropriate program.

**Department of Veterans Affairs (VA)
Patient-Centered Community Care (PC3 or PCCC)**

1-855-PCCCVET (1-855-722-2838)

**Veterans Access, Choice and
Accountability Act of 2014 (VACAA)**
Veterans Choice Program (VCP)

1-866-606-8198



www.triwest.com